TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS SURGICAL CENTER

Respondent Name
LIBERTY MUTUAL FIRE INSURANCE

MFDR Tracking Number
M4-17-3442-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
JULY 24, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "At this time we are requesting that this claim paid in accordance with the 2016 Texas Workers Compensation Fee Schedule and Guidelines."

Amount in Dispute: $890.43

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider was paid at 235% with implants included on the original review. The provider was paid this amount based on the Texas Workers Compensation fee schedule rules which stipulates that the provider must request separate reimbursement on their original bill, submit the certification as required by Section 134.403(g)(1) and 134.404(g)(1) along with the implant invoices. Because the provider failed to submit all of this information on the original bill, the Payor reimbursed the provider at the implant included rate of 235%."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 17, 2017	Ambulatory Surgical Care Services for CPT Code 25400	$0.00	$0.00
	HCPCS Code L8699	$890.43	$0.00
TOTAL		$890.43	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §133.10 sets out the general medical billing procedures.
3. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, sets out the reimbursement guidelines for ambulatory surgical care services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

    - B839-In accordance with CMS guidelines, this service does not warrant a separate payment.
    - 193-The charge for this procedure exceeds the fee schedule allowance.

Issues

1. What is the applicable rule for determining reimbursement of the disputed services?

2. Is the respondent's denial of payment supported?

Findings

1. The fee guideline for Ambulatory Surgical Care services is found in 28 Texas Administrative Code §134.402.

2. The requestor is seeking separate reimbursement for implantables that were provided as part of the ambulatory surgical care services in dispute. The requestor in this case argues that it should have been paid separately for the implanatables and is due an additional reimbursement of $890.43.

    28 Texas Administrative Code §134.402(d) states,

    > For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section.

    HCPCS code L8699 is defined as "Prosthetic implant, not otherwise specified."

    28 Texas Administrative Code §134.402 (f)(1)(A) and (B) states, "Reimbursement for non-device intensive procedures shall be:

    (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent; or

    (B) if an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the non-device intensive procedure shall be the sum of:

    (i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission; and

    (ii) the Medicare ASC facility reimbursement amount multiplied by 153 percent."

    28 Texas Administrative Code §133.10(f)(1)(W) requires that the facility use a specific field on the CMS-1500 to make a request for separate reimbursement: "All information submitted on required paper billing forms must be legible and completed in accordance with this section. The parenthetical information following each term in this section refers to the applicable paper medical billing form and the field number corresponding to the medical billing form. (1) The following data content or data elements are required for a complete professional or noninstitutional medical bill related to Texas workers' compensation health care: (w) supplemental information (shaded portion of CMS-1500/fields 24d - 24h) is required when the provider is requesting separate reimbursement for surgically implanted devices or when additional information is necessary to adjudicate payment for the related service line."

    Review of the submitted medical bills finds that neither the original billing, nor the bills submitted for reconsideration contain the required data in fields 24d-24h. For that reason, the Division finds that the carrier in this case correctly deferred to the higher 235% rate outlined in §134.402(f)(1)(A) as noted in their

position statement. The division finds that the requestor is not due separate reimbursement for the implantable in dispute.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		8/16/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.